FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039230

Facility Name: OTTAWA PAVILION

Address: 800 E. CENTER ST. (Number) OTTAWA (City) 61350 (Zip Code)

County: LASALLE

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3919766001

Date of Initial License for Current Owners: 12/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,765	3,765	8
9	SNF/PED					9
10	ICF	20,595	7,398		27,993	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,595	7,398	3,765	31,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.12%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,580

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	185,491	16,601	4,145	206,237		206,237		206,237			1
2	Food Purchase		163,663		163,663		163,663	(1,917)	161,746			2
3	Housekeeping	117,205	22,976		140,181		140,181		140,181			3
4	Laundry	42,278	9,587	1,010	52,875		52,875		52,875			4
5	Heat and Other Utilities			107,813	107,813		107,813	795	108,608			5
6	Maintenance	51,089	26,278	9,362	86,729		86,729	6,161	92,890			6
7	Other (specify):*			6,469	6,469		6,469	434	6,903			7
8	**TOTAL General Services**	396,063	239,105	128,799	763,967		763,967	5,473	769,440			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,394,733	59,007	87,540	1,541,280		1,541,280	(863)	1,540,417			10
10a	Therapy	150,845	25	138	151,008		151,008		151,008			10a
11	Activities	84,566	4,482	3,425	92,473		92,473		92,473			11
12	Social Services	27,634		2,585	30,219		30,219		30,219			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,657,778	63,514	99,688	1,820,980		1,820,980	(863)	1,820,117			16
	C. General Administration											
17	Administrative	58,705		213,600	272,305		272,305	(98,212)	174,093			17
18	Directors Fees											18
19	Professional Services			38,467	38,467		38,467	(2,857)	35,610			19
20	Dues, Fees, Subscriptions & Promotions			25,138	25,138		25,138	(11,179)	13,959			20
21	Clerical & General Office Expenses	54,193	17,904	74,276	146,373		146,373	(13,211)	133,162			21
22	Employee Benefits & Payroll Taxes			351,468	351,468		351,468		351,468			22
23	Inservice Training & Education			1,035	1,035		1,035		1,035			23
24	Travel and Seminar							438	438			24
25	Other Admin. Staff Transportation			2,381	2,381		2,381		2,381			25
26	Insurance-Prop.Liab.Malpractice			104,990	104,990		104,990	2,387	107,377			26
27	Other (specify):*							19,078	19,078			27
28	**TOTAL General Administration**	112,898	17,904	811,355	942,157		942,157	(103,556)	838,601			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,166,739	320,523	1,039,842	3,527,104		3,527,104	(98,946)	3,428,158			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,044	
	REPAIRS & MAINTENANCE		101	
			0	4,145
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,010	
			0	1,010
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		46,311	
	ELECTRICITY		49,612	
	WATER		11,890	
	CABLE TV - LOBBY		0	
			0	107,813
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,539	
	ELEVATOR MAINTENANCE & REPAIR		3,919	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,904	
	FIRE SERVICE		0	
			0	
			0	
			0	9,362
7	**OTHER**			
	SCAVENGER		6,469	
	SECURITY SERVICE		0	6,469
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	82,620	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,380	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	540	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	87,540
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	138	138
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,425	
			0	3,425
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,585	
			0	2,585
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	213,600	213,600
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,078	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	33,389	
			0	38,467
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,361	
	EMPLOYEE WANT ADS	XIX F	6,776	
	CONTRIBUTIONS	VI 20 XIX F	540	
	DUES & SUBSCRIPTIONS	XIX F	4,615	
	LICENSES & PERMITS	XIX F	497	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,349	25,138
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)			
	EQUIPMENT REPAIR & MAINTENANCE		14,096	
	OUTSIDE CLERICAL SERVICES		36,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,662	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,118	
	MESSENGER SERVICE		0	
			0	74,276

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	165,003	
	UNEMPLOYMENT COMPENSATION	XIX D	32,529	
	WORKERS COMPENSATION INSURANCI	XIX D	72,596	
	HOSPITALIZATION INSURANCE	XIX D	72,774	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,566	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	351,468
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,035	1,035
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,381	2,381
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		104,990	104,990
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,039,842

Facility Name & ID Number OTTAWA PAVILION #0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,260	35,260		35,260	112,239	147,499			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,809	59,809		59,809	272,635	332,444			32
33	Real Estate Taxes			50,607	50,607		50,607	1,930	52,537			33
34	Rent-Facility & Grounds			378,000	378,000		378,000	(378,000)				34
35	Rent-Equipment & Vehicles			7,030	7,030		7,030	5,316	12,346			35
36	Other (specify):*											36
37	**TOTAL Ownership**			530,706	530,706		530,706	14,120	544,826			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,518		106,518		106,518	(741)	105,777			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		106,518	65,153	171,671		171,671	(741)	170,930			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,166,739	427,041	1,635,701	4,229,481		4,229,481	(85,567)	4,143,914			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,895)	30		9
10	Interest and Other Investment Income	(5,998)	32		10
11	Discounts, Allowances, Rebates & Refunds	(954)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(963)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,662)	21		18
19	Entertainment		20		19
20	Contributions	(540)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(5,021)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(11,361)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	435			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,959)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(46,608)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (46,608)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (85,567)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 435	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	435		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,917)	0	0	0	0	0	0	0	0	0	0	(1,917)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	795	0	0	0	0	0	0	0	0	795	5
6	Maintenance	435	0	634	5,092	0	0	0	0	0	0	0	6,161	6
7	Other (specify):*	0	0	0	0	434	0	0	0	0	0	0	434	7
8	**TOTAL General Services**	(1,482)	0	1,429	5,092	434	0	0	0	0	0	0	5,473	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(863)	0	0	0	0	0	(863)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(863)	0	0	0	0	0	(863)	16
	C. General Administration													
17	Administrative	0	(213,600)	0	115,388	0	0	0	0	0	0	0	(98,212)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,021)	0	2,164	0	0	0	0	0	0	0	0	(2,857)	19
20	Fees, Subscriptions & Promotions	(11,901)	0	722	0	0	0	0	0	0	0	0	(11,179)	20
21	Clerical & General Office Expenses	(10,662)	(36,400)	29,089	4,762	0	0	0	0	0	0	0	(13,211)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	438	0	0	0	0	0	0	0	0	438	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,387	0	0	0	0	0	0	0	0	2,387	26
27	Other (specify):*	0	0	4,973	0	14,105	0	0	0	0	0	0	19,078	27
28	**TOTAL General Administration**	(27,584)	(250,000)	39,773	120,150	14,105	0	0	0	0	0	0	(103,556)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,066)	(250,000)	41,202	125,242	14,539	(863)	0	0	0	0	0	(98,946)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,895)	113,444	2,690	0	0	0	0	0	0	0	0	112,239	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,998)	276,087	2,546	0	0	0	0	0	0	0	0	272,635	32
33	Real Estate Taxes	0	0	1,930	0	0	0	0	0	0	0	0	1,930	33
34	Rent-Facility & Grounds	0	(378,000)	0	0	0	0	0	0	0	0	0	(378,000)	34
35	Rent-Equipment & Vehicles	0	0	5,316	0	0	0	0	0	0	0	0	5,316	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,893)	11,531	12,482	0	0	0	0	0	0	0	0	14,120	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(741)	0	0	0	0	0	(741)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(741)	0	0	0	0	0	(741)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,959)	(238,469)	53,684	125,242	14,539	(1,604)	0	0	0	0	0	(85,567)	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 213,600	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (213,600)	1
2	V	21	BOOKKEEPING SERVICES	36,400	" "			(36,400)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	378,000	OTTAWA PAVILION BUILDING LLC			(378,000)	7
8	V	30	DEPRECIATION		" "		113,444	113,444	8
9	V	32	INTEREST		" "		276,087	276,087	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 628,000			$ 389,531	$ * (238,469)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 795	$ 795	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	634	634	16
17	V	7	EMP. BEN. - GEN, SERVICES		" " "	100.00%			17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	2,164	2,164	18
19	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	722	722	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	29,089	29,089	20
21	V	24	SEMINARS AND TRAVEL		" " "	100.00%	438	438	21
22	V	26	INSURANCE		" " "	100.00%	2,387	2,387	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "	100.00%	4,973	4,973	23
24	V	30	DEPRECIATION		" " "	100.00%	2,690	2,690	24
25	V	32	INTEREST		" " "	100.00%	2,546	2,546	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	1,930	1,930	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	5,316	5,316	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 53,684	$ * 53,684	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 5,092	$ 5,092	15
16	V	10	NURSING CMP. - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	28,396	28,396	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	41,662	41,662	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%	7,425	7,425	20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%	7,834	7,834	21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%			22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%	7,208	7,208	24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	9,778	9,778	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	13,085	13,085	27
28	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	4,762	4,762	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 125,242	$ * 125,242	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 434	$ 434	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP.BEN. - M. MAUER		" " "	100.00%	901	901	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	1,387	1,387	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%	3,924	3,924	20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%	2,964	2,964	21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%			22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%	590	590	24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,414	1,414	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,987	1,987	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	938	938	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 14,539	$ * 14,539	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	19	PROFESSIONAL FEES	4,200	" " "		4,200		16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	3,419	LINCOLN MEDICAL SUPPLIES, INC.		2,556	(863)	21
22	V	39	ANCILLARY EXPENSE	2,936	" " "		2,195	(741)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,555			$ 8,951	$ * (1,604)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 41,662	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	28,396	17-7	2
3	SHEILA BOGEN		ADMINISTRATIVE					SALARY	7,208	17-7	3
4	SHARON AARON		CLERICAL					SALARY	4,762	21-7	4
5	DENNIS NEHMER		MAINTENANCE					SALARY	5,092	6-7	5
6	SUSAN KOPLIN HARAMARAS		ADMINISTRATIVE					SALARY	7,834	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 94,954		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	423,801	12	$ 10,611	$	31,758	$ 795	1
2	6	REPAIR & MAINT.	" "	423,801	12	8,462		31,758	634	2
3	7	EMP. BEN. - GEN, SERVICES	" "	423,801	12			31,758	0	3
4	19	PROFESSIONAL FEES	" "	423,801	12	28,879		31,758	2,164	4
5	20	DUES AND SUBSCRIPTION	" "	423,801	12	9,628		31,758	722	5
6	21	CLERICAL & GENERAL	" "	423,801	12	388,179	279,093	31,758	29,089	6
7	24	SEMINARS AND TRAVEL	" "	423,801	12	5,844		31,758	438	7
8	26	INSURANCE	" "	423,801	12	31,856		31,758	2,387	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	423,801	12	66,362		31,758	4,973	9
10	30	DEPRECIATION	" "	423,801	12	35,898		31,758	2,690	10
11	32	INTEREST	" "	423,801	12	33,975		31,758	2,546	11
12	33	REAL ESTATE TAXES	" "	423,801	12	25,761		31,758	1,930	12
13	35	EQUIPMENT RENTAL	" "	423,801	12	70,935		31,758	5,316	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 716,390	$ 279,093		$ 53,684	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 59,901	$ 59,901	3	$ 5,092	1
2	10	NURSING CMP. - SUE G.	" "							2
3	17	ADMIN. CMP. - M. MAUER	" "	40	11	373,726	373,726	3	28,396	3
4	17	ADMIN. CMP. - M. AARON	" "	40	9	490,141	490,141	3	41,662	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,118	191,118			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	40	3	49,500	49,500	6	7,425	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	7	69,067	69,067	5	7,834	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	77,417	77,417			8
9	17	ADMIN. CMP. - E. CASSON	" "							9
10	17	ADMIN. CMP. - S. BOGEN	" "	11	2	40,545	40,545	2	7,208	10
11	17	ADMIN. CMP. - S. LEVY	" "	45	11	128,818	128,818	3	9,778	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	9	153,735	153,735	4	13,085	13
14	21	CLERICAL. - S. AARON	" "	40	11	62,676	62,676	3	4,762	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,708,644	$ 1,708,644		$ 125,242	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	9	$ 5,106	$	3	$ 434	1
2	15	EMP. BEN. - SUE G.	" "							2
3	27	EMP.BEN. - M. MAUER	" "	40	11	11,858		3	901	3
4	27	EMP. BEN. - M. AARON	" "	40	9	16,312		3	1,387	4
5	27	EMP. BEN. - F. AARON	" "	45	6	32,071				5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	40	3	26,160		6	3,924	6
7	27	EMP. BEN. - S. KOPLIN	" "	40	7	26,142		5	2,964	7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	6,801				8
9	27	EMP. BEN. - E. CASSON	" "							9
10	27	EMP. BEN. - S. BOGEN	" "	11	2	3,320		2	590	10
11	27	EMP. BEN. - S. LEVY	" "	45	11	18,630		3	1,414	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	4,292				12
13	27	EMP. BEN. - NON-OWNER	" "	45	9	23,348		4	1,987	13
14	27	EMP. BEN. - S. AARON	" "	40	11	12,346		3	938	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 186,386	$		$ 14,539	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "						4,200	3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						2,556	9
10	39	ANCILLARY EXPENSE	" "						2,195	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 8,951	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HAJEK/REICHERT		X	MORTGAGE	$36,043.00	12/01/98	$ 3,800,000	$ 3,402,438	12/18	9.7500	$ 276,087	1
2												2
3	SHAREHOLDERS	X		WORKING CAPITAL				455,500			10,488	3
4	INTERCOMPANY	X		WORKING CAPITAL			350,000	350,000			26,687	4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL				303,800		PRIME+	18,395	6
7			X	INSURANCE				28,773			4,239	7
8	RELATED PARTY	X									2,546	8
9	TOTAL Facility Related				$36,043.00		$ 4,150,000	$ 4,540,511			$ 338,442	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,150,000	$ 4,540,511			$ 338,442	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	52,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	50,607	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,393)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	52,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	50,607	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	50,028	8
1999	49,910	9
2000	50,378	10
2001	50,521	11
2002	50,607	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 50,607.08	$ 50,607.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,607.08	$ 50,607.08

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,128 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1998		$ 3,143,000	$ 83,151	39	$ 83,151	$	$ 419,225	4
5											5
6											6
7											7
8					33,242	852	35	950	98	9,814	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1994	13,015	333	39	333		3,143	9
10	WALLPAPER			1995	18,314	470	39	470		3,873	10
11	DRYWALL IN CORRIDOR			1995	17,550	450	39	450		3,731	11
12	HANDRAILS			1995	7,839	201	39	201		1,650	12
13	SECURITY DOOR			1995	1,602	41	39	41		330	13
14	MIXING VALVE & WATER HEATER			1995	756	19	39	19		153	14
15	HANDRAIL & BUMPER			1996	6,895	177	39	177		1,409	15
16	HANDRAIL & BUMPER			1996	721	18	39	18		138	16
17	ALARM			1996	1,146	29	39	29		215	17
18	PANIC DEVICE			1996	1,550	40	39	40		288	18
19	REPLACE RECONNECT SWITCH & STARTER			1996	1,074	28	39	28		199	19
20	DRAPERIES			1996	13,334	342	39	342		2,408	20
21	DRAPERY, CARPETING			1997	12,786	328	39	328		2,038	21
22	PIPING WORK, HEAT/COOL UNITS			1997	4,341	111	39	111		694	22
23	HEAT/COOL UNITS			1998	4,732	131	39	131		724	23
24	OFFICE REMODELING			1998	1,475	38	39	38		211	24
25	SHELVING/COOLER			1998	1,493	28	39	28		163	25
26	BOILER, HEAT/COOL UNIT			1999	10,441	268	39	268		1,309	26
27	ALARM SYSTEM			1999	2,853	73	39	73		362	27
28	WINDOWS			1999	19,785	507	39	507		2,330	28
29	FOLDING STEEL GATE			1999	884	23	39	23		93	29
30	REMODELING DISHWASHER ROOM			1999	5,000	128	39	128		517	30
31	DRAPERIES			1999	6,439	165	39	165		694	31
32	PARKING LOT PAVING			1999	1,834	47	39	47		215	32
33	BASEMENT REMODEL			2000	15,203	553	27.5	553		1,849	33
34	WINDOW REPAIR -- DOOR			2000	3,026	110	27.5	110		367	34
35	FEED PUMP -- HOT WATER VALVE			2000	4,131	150	27.5	150		503	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SPRINKLER SYSTEM REPAIR	2000	$ 1,175	$ 43	27.5	$ 43	$	$ 144	37
38	AIR CONDITIONER	2000	1,273	46	27.5	46		154	38
39	CARPETING -- SHEERS	2000	5,693	711	20	285	(426)	2,106	39
40	BASEMENT REMODEL	2001	20,088	733	27.5	733		1,810	40
41	BIOLER/SPRINKLER REPAIRS	2001	10,031	365	27.5	365		903	41
42	BOILER REPAIR/PUMP/COMPRESSOR	2002	11,888	432	27.5	432		583	42
43	HEATER	2002	2,938	107	27.5	107		123	43
44	BASEMENT REMODEL	2002	18,705	680	27.5	680		997	44
45	BOILER REPAIR/PUMPS/CONDENSING UNIT	2003	9,701	162	27.5	162		162	45
46	SPRINKLER SYSTEM REPAIR	2003	16,320	272	27.5	272		272	46
47	DOOR CAMERAS AND LOCKS	2003	4,591	76	27.5	76		76	47
48	AIR CONDITIONER 5 TON	2003	1,960	30	27.5	30		30	48
49	SERVICE SINK	2003	802	13	27.5	13		13	49
50	WALL REPAIR - WATER DAMAGE	2003	1,370	23	27.5	23		23	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,460,996	$ 92,504		$ 92,176	$ (328)	$ 466,041	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 188,571	$ 17,197	$ 17,316	$ 119	10	$ 91,020	71
72	Current Year Purchases	11,277	5,222	564	(4,658)	10	564	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	377,394	31,417	31,895	478	10	365,493	74
75	TOTALS	$ 577,242	$ 53,836	$ 49,775	$ (4,061)		$ 457,077	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1999 DODGE RAM VAN	2002	$ 13,563	$ 4,340	$ 4,340	$	5	$ 7,053	76
77	RELATED PARTY			4,219	714	1,208	494		4,135	77
78										78
79										79
80	TOTALS			$ 17,782	$ 5,054	$ 5,548	$ 494		$ 11,188	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,456,020	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 151,394	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 147,499	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,895)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 934,306	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 7,030 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				91,675		91,675	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB & SUPPLIES						14,843		14,843	13
14	TOTAL			$		$	$ 106,518		$ 106,518	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,500)	402,179		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,211		6
7	Other Prepaid Expenses	2,456		7
8	Accounts Receivable (owners or related parties)	187,700		8
9	Other(specify): R E TAX ESCROW	49,924		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 663,470	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	284,754		15
16	Equipment, at Historical Cost	213,411		16
17	Accumulated Depreciation (book methods)	(211,628)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSIT	2,685		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 289,222	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 952,692	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 305,854	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	311,807		29
30	Accrued Salaries Payable	190,869		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,868		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000		32
33	Accrued Interest Payable	5,532		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 876,930	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	805,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 805,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,682,430	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (729,738)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 952,692	$	48

*(See instructions.)

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (350,229)	1
2	Restatements (describe):		2
3		(7,023)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (357,252)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(372,486)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (372,486)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (729,738)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,779,781	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,779,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,126	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 70,126	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	136	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 136	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,998	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,998	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	954	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 954	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,856,995	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	763,967	31
32	Health Care	1,820,980	32
33	General Administration	942,157	33
	B. Capital Expense		
34	Ownership	530,706	34
	C. Ancillary Expense		
35	Special Cost Centers	106,518	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,229,481	40
41	**Income before Income Taxes (line 30 minus line 40)****	(372,486)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (372,486)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,693	1,713	$ 41,405	$ 24.17	1
2	Assistant Director of Nursing	124	124	2,976	24.00	2
3	Registered Nurses	12,853	13,450	289,259	21.51	3
4	Licensed Practical Nurses	13,165	13,935	251,384	18.04	4
5	Nurse Aides & Orderlies	68,545	74,845	768,953	10.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,638	5,086	150,845	29.66	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	2,165	24,179	11.17	9
10	Activity Assistants	7,682	8,272	60,387	7.30	10
11	Social Service Workers	2,209	2,526	27,634	10.94	11
12	Dietician					12
13	Food Service Supervisor	2,028	2,269	33,320	14.68	13
14	Head Cook	301	1,050	9,387	8.94	14
15	Cook Helpers/Assistants	16,774	17,683	142,784	8.07	15
16	Dishwashers					16
17	Maintenance Workers	4,298	4,719	51,089	10.83	17
18	Housekeepers	15,446	16,526	117,205	7.09	18
19	Laundry	5,636	5,866	42,278	7.21	19
20	Administrator	1,979	2,269	58,705	25.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,583	4,817	54,193	11.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,411	3,820	40,756	10.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	167,265	181,135	$ 2,166,739 *	$ 11.96	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	174	$ 4,044	1-3	35
36	Medical Director	120	6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	110	4,380	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	3	138	10a-3	43
44	Activity Consultant	73	3,425	11-3	44
45	Social Service Consultant	47	2,585	12-3	45
46	Other(specify) PSYCHIATRIC	12	540	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	538	$ 21,112		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses	2,241	81,580	10-3	51
52	Nurse Aides	32	1,040	10-3	52
53	TOTAL (lines 50 - 52)	2,272	$ 82,620		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARGIE LYLE	ADMIN	0	$ 58,705
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,705

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 213,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 213,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR	ACCOUNTING	$ 11,640
FROST RUTTENBERG	ACCOUNTING	3,635
SACHNOFF, WEAVER	LEGAL	3,294
ARLINGTON, KAUFMAN	LEGAL	5,021
PERSONNEL PLANNERS	UC CONSULTANT	1,596
ECONOCARE	PURCHASING CONSLT	2,142
HEALTH DATA SYS	DATA PROCESSING	4,539
DYNAMIC REHAB CONSLT	DATA PROCESSING	4,200
ASSURANCE AGENCY	INSURANCE	2,400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 38,467

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 72,596
Unemployment Compensation Insurance		32,529
FICA Taxes		165,003
Employee Health Insurance		72,774
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		8,566
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,776
Health Care Worker Background Check	1,349
(Indicate # of checks performed 112)	
MARKETING/ADV/PROMO	11,361
TRUST/FRANCHISE/CONTRIB/ETC	540
LICENSES & PERMITS	297
DUES & SUBSCRIPTIONS	4,615
MGMT CO ALLOCATION	722
TRUST/FRANCHISE/CONTRIB/ETC	(540)
Less: Public Relations Expense	(0)
Non-allowable advertising	(11,361)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,959

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
RELATED PARTY	438
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 438

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2000	$ 2,607		$ 434	$ 869	$ 869	$ 435	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,607		$ 434	$ 869	$ 869	$ 435	$	$	$	$	$

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC $4,082**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,317** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,153**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees